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HOW DOES THERAPY WORK?

In decades past, researchers and policymakers focused on the question "Does psychotherapy work?" Researchers have now conclusively established the overall efficacy of psychologically informed treatments (Barlow, 2001; Hubble, Duncan, & Miller, 1999; Nathan & Gorman, 2002a; Norcross, 2002; Wampold, 2001), and the public, almost universally, has accepted psychotherapy as a viable remedy to many of life's problems (cf. Harris Interactive, 2004).

Now that that question has been answered (i.e., yes, psychotherapy does work), a new question has been posed: "How does psychotherapy work?" The answers to this question are not academic but have ramifications for everyone involved in the practice of psychotherapy. For example, policymakers at the governmental level and in the private sector (e.g., the insurance industry) increasingly determine whether therapy sessions will be reimbursed. For many patients, if not most, reimbursement is a key factor in deciding whether to seek or continue psychotherapy. Thus, policymakers in both the government and the insurance industry, and the providers they influence, need to better understand how seemingly disparate forms of psychotherapy work in equally effective ways. Researchers and theorists, rather than becoming polarized into warring camps, need to find a theoretical framework that cuts across all of the therapeutic approaches that have been empirically shown to be effective. An important purpose of this book is to provide such a framework.

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So far, those claiming answers to this question have polarized into two camps. Members of the first, designated here as the *best-practices group* (often identified with *empirically supported treatments* [ESTs]), argue that sufficient evidence exists to prove that specific psychotherapy protocols are differentially therapeutic for specific therapy populations (e.g., people with major depression, people who abuse substances). The second camp, designated here as the *common-factors group* (often identified with the *therapeutic alliance*, or the *therapeutic relationship*), presents compelling data that all mainstream approaches to psychotherapy work equally well for most clinical populations, provided that a strong therapeutic alliance and other common curative factors are operating (e.g., a positive client-therapist relationship, a working alliance, perceived empathy, goal agreement, and collaboration, among other factors). Perhaps because of its close correspondence to current medical practice, the best-practices group has gradually gained the most credence with policymakers, and the result has been an increasing pressure toward conformity in the day-to-day conduct of psychotherapy. For example, across the United States, state mental health administrators and funding boards are requiring that providers adopt particular treatment models and protocols for specific clinical populations. Their most recent initiative comes as a demand that clinicians use the most effective therapies as they interpret them (Presidential Task Force, American Psychological Association, 2005; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Professionals on the front line, treating patients, are confused and frustrated. Must we learn a different best practice for each clinical population? How do we practice with the majority of clients who have a mixture of problems and who fall into more than one specific clinical population (e.g., those who experience both depression and substance abuse?) Do we have no autonomy in practicing our profession?

As the debate continues between the best-practices and common-factors groups, with no end in sight, both have become increasingly polarized and increasingly bent on claiming the lion's share of positive outcomes for their approach. (Later in this chapter we review some of this research.) On one point, they both concur: The stakes are high and, no doubt, are getting higher, as the funds to pay for therapy become increasingly harder to find.

THE GOLDEN THREAD

In Greek mythology, the golden thread helped the warrior Theseus safely find his way to the center of a labyrinth and back out. It traced the pathway through seemingly endless, disorienting corridors in which one's movement was at times contrary to intuition. Today, there are a large and growing num-

ber of different, purportedly effective psychotherapies. However, their differences in approach and suggested mechanisms for change appear to contradict each other, creating a modern-day labyrinth for theorists, researchers, policymakers, professors, and graduate students. What makes these treatments effective? What do they have in common? What pathways do they share, and what thread, if any, connects them? Those encountering this dilemma cry out for a modern golden thread to find their way. We contend that second-order change is that golden thread.

WHO WILL MOST BENEFIT FROM READING THIS BOOK?

This book's audience includes those practical theorists, researchers, policymakers, professors, and graduate students who are struggling to find a pathway through the myriad effective psychotherapies and who are seeking a common thread that connects effective interventions. Each group runs into its own unique frustrations that are addressed by the second-order change model that we introduce.

Applied theorists have struggled for decades with the question of how psychotherapies are connected with one another. They have synthesized a number of useful schemes to integrate approaches, including technical eclecticism (i.e., using the most effective techniques without adapting the theories that underlie them); theoretical integration (synthesizing different theories underlying different approaches within a superordinate unifying theory); and a common-factors approach (identifying the core elements shared by all effective psychotherapies; cf. Norcross & Goldfried, 2005; for other perspectives, see psychological resources such as the *Journal of Psychotherapy Integration*). Each approach to integration has merit, and yet each is unable to explain the unifying pattern of change that underlies all effective psychotherapy models. By following the thread of second-order change, these practical theorists may gain a greater capacity for integration.

As researchers argue over the relative contributions to effective treatment of therapeutic techniques versus the therapeutic relationship, they have become caught in an unresolvable debate. This debate is reminiscent of Werner Heisenberg's (1958) famous *uncertainty principle* in physics (i.e., light being observed behaves as either particles or waves, depending on how it is measured). The kind of assumptions these psychotherapy researchers make, the subsequent questions they ask, and the way they approach answering them, determine what they find. The questions they ask and the kind of observations they make determine whether effective therapies are a product of either particular techniques or significant relationships. For these researchers, viewing techniques and relationships as inseparable aspects of second-order change should open new pathways of investigation.

Policymakers are now seeking the best treatments for clients within an economic climate of limited resources. They are increasingly insisting that

so-called "best-practice protocols" be used by therapists in order for those services to be reimbursed. Although policymakers are trying to hold providers accountable for positive outcomes, providers are finding it nearly impossible to learn the broad array of seemingly very different best-practice approaches. Additionally, they complain that the mandates are much too restrictive. The second-order change model holds promise that policymakers will create more flexible guidelines that will allow practitioners a way of integrating effective approaches within a perspective that more flexibly fits themselves and their clients.

Professors and graduate students find themselves trapped in somewhat similar dilemmas. Should they not be teaching, and learning, the major theories of psychotherapy? And yet, once learned, how do they relate to one another? Is it a matter of picking one's favorite brand, or are there best practices to be learned for each disorder? Is it all about relationships or all about best practices? And what about diversity? How do these effective approaches handle differences between providers and clients, and how do they apply to most clients who do not have just one kind of problem? Most clinical trials have been conducted with clients with only one focused problem. For professors and graduate students, the second-order change model offers a hopeful framework for finding new pathways through these questions. We view this as the modern golden thread through the labyrinth of therapies that work. First, however, we will profit by taking another look at the current state of affairs in psychotherapy research.

THE GREAT SCHISM: RESEARCH PERSPECTIVES

At the risk of hyperbole, we maintain that the future of psychotherapy is uncertain. The prize is the undisputed claim to the lion's share of positive outcomes. For the common-factors contingent, the contest is already decided, regardless of how much influence the best-practices group may already wield.

For example, in an oft-repeated analysis of psychotherapy studies, Michael Lambert (1992; Asay & Lambert, 1999) surmised that a therapist's model or technique accounts for no more than 15% of the successful outcome variance. This effect was found to be no more potent than that explained by positive expectancy or placebo, also 15%. Next in importance for outcome, at 30%, were relationship-mediated variables, which accounted for as much as the previous elements combined. What is most impressive is that Lambert argued that, with 40% of the variance, extratherapeutic factors—those that are part of the client or client's environment that aid in recovery regardless of the client's formal participation in treatment—yielded the greatest impact on change. Lambert's findings markedly depart from the time-honored tradition of celebrating the contribution of the therapist's theoretical model and technique.

In a similar vein, Bruce Wampold conducted and published a series of meta-analyses¹ of the psychotherapy outcome research literature. As reported in his book, *The Great Psychotherapy Debate: Models, Methods, and Findings* (2001), he revised the percentagewise contribution of the factors discussed earlier. First, the total portion of the outcome variance attributable to treatment-mediated variables markedly diminished; that is, therapeutic modality (the therapist's model and technique) fell from 15% to only 8%. At least 70% of psychotherapeutic effects, he added, are general effects, representing the common factors underlying all psychotherapies. The remaining 22% of the variability is unexplained but is partly attributable to client differences.

With his startling (at least to some) results in hand, Wampold concluded that the medical model, implicit in the EST movement, which assumes that the outcomes of therapy originate in the specific ingredients built into a given treatment, is out of step with the facts. He endorses an alternative, a pantheoretical position, what he terms a *contextual model*. This model, closely associated with the now-famous work of Johns Hopkins University's Jerome Frank (see Frank & Frank, 1991), upholds the importance of common factors in promoting positive change. Wampold emphasized that there is no connection between the supposed underlying causes of psychological suffering and the treatments that effectively ameliorate it. Instead, he highlighted the critical role of the *healing context*: the therapist's and the client's belief in therapy, the relationship between the therapist and the client, the rationale for the treatment, the actions consistent with the rationale, and the meaning that the client attributes to therapy (Wampold, 2001).

Other works, such as *The Heart and Soul of Change: What Works in Therapy* (Hubble et al., 1999) and *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients* (Norcross, 2002), enlarge and underscore the body of literature upholding the common factors as important, if not the most essential, elements of effective psychotherapy. The evidence reviewed in these texts suggests again that the efficacy of mental health treatments will not be found in a specific therapy approach on its own. Instead, to understand the effectiveness of treatment, one has to look at the function and power of the therapeutic alliance and the resources clients bring to the work.

For all the forcefulness and authority derived from their research and writing, the common-factors contingent has yet to unseat the EST or best-practices group. The proponents of ESTs have amassed an imposing body of experimental evidence that, from their perspective, makes their case, hands

¹Meta-analysis is a type of research in which sophisticated statistical techniques are used to review the range of studies that have been conducted on a similar research question. Significant effect sizes found in isolated studies may attenuate when meta-analytic techniques are applied. The effectiveness of ESTs is often based on effect sizes found in limited clusters of studies. In psychotherapy research, meta-analysis has not been able to verify the results found in the vast majority of ESTs that have been studied.

down. For instance, "exposure treatments" are frequently cited as the most effective interventions for anxiety (cf. Barlow, 2002). Certain texts, such as *A Guide to Treatments That Work* (2nd ed.; Nathan & Gorman, 2002a) and *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual* (Barlow, 2001), are encyclopedic in their review of ESTs for a wide range of client problems. So impressive are these results that state and federal regulatory bodies are demanding that reimbursement from their resources become contingent on providers proving that they have used an EST appropriate to the problem treated.

The prospect of having a specific intervention for a given type of problem is especially appealing. The idea that therapists might possess the psychological equivalent of a pill or precision-guided weapon for emotional distress is also one that strongly resounds with the public and policymakers. Additionally, no one could argue with the success of the idea of problem-specific interventions in the field of medicine (e.g., surgery for acute appendicitis).

Setting aside the arguments for and against outside entities telling therapists how to do their jobs, encouraging practice of the most successful treatments is a very worthy and rational undertaking. If it is the case, as the best-practices group maintains, that we are on the verge of compiling a dependable psychological formulary, this is great news for clients, payers, and practitioners. In fact, it would mark the dawn of a new era, a revolution in clinical work. The usual doubt as to what to do in addressing a particular complaint would be gone. Sure and confident steps could be recommended to clients and, with their informed consent, the treatment immediately commenced. After the proper dosing and prescribed course, success would be evaluated and, if needed, modifications made to the treatment plan. A true standard of care could be established, with all that it would entail for training, supervision, continuing education, quality control, and funding. At the same time, the best of what is known about the therapy relationship (and other helpful treatment components; e.g., positive expectancy) from the common-factors literature could be applied to help ensure the client's compliance with the treatment regimen. Finally, the vexing problem of integration would be settled. Integration would be achieved at an empirical and practical level—hierarchies of therapies that best treat specific complaints.

In contrast, if, as the common-factors contingent contends, specialized treatments or ESTs are largely a chimera, then a major disservice is being perpetrated. In due time, those therapies currently touted as superior to the rest might be perceived as fads in a field already tarnished by so many misplaced enthusiasms. The stain on the profession sponsored by the inpatient-for-profit scandals, the recovered- or past-memories flap, and singular treatments still brings embarrassment. Those outside the field looking to pull the plug on psychologically based treatment would have yet another reason for giving physicians more control in the market. Psychotropic medication, the mainstay of the new biological psychiatry, is, after all,

medicine, and everyone "knows" medicine works. Many psychologists, perhaps already having realized the prognosis, are clamoring to obtain prescription privileges.

From another perspective, should the common-factors position be correct, the structure of the profession could conceivably be challenged. For instance, if all treatments work equally well, and their effectiveness is found, as Wampold (2001) asserted, in the healing context and not in theories and specialized practices, then the current justification for separate training and even licensing of mental health practitioners is suspect. In a world won over by the common-factors contingent, programs of graduate study, with their many departments and different schools, philosophies, and doctrines would find recruitment especially trying. The appetite for specialized preparation in specific therapies with differing levels of certification (e.g., eye movement desensitization and reprocessing) would also be undermined. In time, such undertakings might come to be regarded as just moneymaking schemes for clever entrepreneurs. The implications for the field as a whole abound.

Regardless of what happens in the end, with a few exceptions (Norcross & Goldfried, 2005), neither side in the current debate is especially motivated to yield any ground. As a result, the field is left with two distinct bodies of research offering different visions for clinical practice. Because of this stand-off, it is easy to empathize with those charged with administering mental health services. With limited time, shrinking budgets, and their own pressure groups nipping at their heels, planners must still try to identify and implement the best treatments money can buy. Expecting that the profession will provide them with clear and unbiased guidance any time soon may be a pipe dream.

A PATHWAY TO RESOLUTION

The definitive answer to the question "How does therapy work?" has yet to emerge. Furthermore, any answer that gains eventual acceptance is unlikely to evolve from an either-or proposition. On a moment's reflection, the schism in psychotherapy bears a distressing and strong resemblance to a vicious cycle (and vicious cycles are the hallmarks of problems from the perspective of what we call *first-order change*). The more researchers on the EST side attempt to prove that a particular treatment is the most effective, the more meta-analyses neutralize the findings. The word then goes forth, "All treatments work equally well. No critical technique exists, only relationships that work." Undeterred, the best-practices group pushes back, "Our work demonstrates the superiority of one method over another. We will research and validate the treatments. That will settle the score." More attempts to identify an ultimate therapy then trigger more reviews, more meta-analyses,

and more impassioned claims for the common factors. Little imagination is needed to envision a continuance and escalation of this struggle.

This is an example in itself of what we describe as first-order change in the next chapter. Each view is based on reason and logic. The actions taken by each group not only are appropriate to their position but also affirm and reinforce their respective positions. To do anything otherwise would not make sense. The only way to take different or even opposite action is by moving to a different level of understanding. This kind of shift is what we presently define and extensively discuss as second-order change.

Despite the resilience of the vicious cycle to date, the divisions between the best-practices group and the common-factors contingent are much more apparent than real. Effective psychotherapy is not a member of any one category or owned by any particular advocacy group; on the contrary, all effective treatments are a member of the same class. Put another way, the proponents of technical approaches and of the relationship and common-factors approach are both correct.

Bearing this in mind, the common-factors people seem to be saying "You can't see the forest for the trees! Look at each given treatment, and you will fail to see what is common among all effective interventions." For their part, the best-practices group says "You can't see the trees for the forest! Blending all the effective approaches loses touch with those specific therapies that show differential efficacy." We are saying, "You are right; we agree! Looking is good." To paraphrase Carl Rogers (1957), we agree that the facts are always friendly. Yet it is now time to look in a different direction, to look at the common ground from which the trees grow. After all, whether it is one tree or a forest, they belong together. They spring from the same ground.

In all, the problem facing the profession is not about an ability to see the forest or the trees. In fact, we labor under an overabundance—trees of every size, shape, and description. Instead, the very ground from which a tree or a forest springs bears close examination. Because all effective psychotherapy initiates desired change, it is reasonable to conclude that change itself is the common ground.

By redirecting our attention to the nature of change, it may be possible to repair the rift in psychotherapy and achieve integration. The emphasis shifts from what is instrumental for change (techniques, common factors) to the underlying nature of change. In short, change is at the very core of problem resolution. Everything that a therapist does—or, for that matter, does not do—either supports or detracts from change. At this level of analysis, the many approaches reveal that they promote improvement in surprisingly similar ways. The lyrics, melody, and rhythm may differ, but the song remains the same. Looking at therapies that work from the perspective of how they promote change is a critical shift in viewpoint that allows new questions to be asked, new actions to be taken, and new integration to be understood. It is empowering. It is what we call a second-order change in itself.

In the midst of the claims and counterclaims that have created the schism in our field, we live in a time of accountability. Two pressing questions remain before us. First, what is the common denominator across effective therapies? Second, what do effective therapists do? Answering these questions is the purpose of this book.

OVERVIEW OF THE BOOK

We submit that a unifying perspective on change unites all effective psychotherapy. This shared perspective, termed here *the second-order change model*, weaves through all effective therapies. The foundation of this framework lies in an understanding of the nature of change. Although more types of change have been described (see Bateson, 1979), special attention will be directed to first- and second-order change. *First-order change* is defined as a class of solutions that do not change a problem or make a problem worse. In contrast, *second-order change* is a change of those first-order solutions, which results in a resolution of the problem. First-order change is related to stability; second-order change is related to transformation. First-order change is a change that occurs in a system that itself remains the same. These changes of intensity, frequency, duration, and so on, are solutions taken according to the existing assumptions and tacit rules of a system. Not only do they not change the system; they affirm the system by repeating its assumptions, rules, and patterns. When first-order change turns problematic, it invariably becomes a vicious cycle. First-order change may be seen in the frustrated folly of the client who attempts to force herself to sleep, or in the man who tries to will himself to become passionately aroused for lovemaking. In these and most other human dilemmas, the solutions become the problem. They create vicious cycles. Second-order change offers solutions that are most often viewed as counterintuitive or paradoxical from the original perspective. Sleep or sexual arousal occurs spontaneously as we allow ourselves to become immersed in the situation. As we may know, the answer to falling asleep or becoming aroused is to stop trying to will it to be so. Yet such a shift for the person caught in these dilemmas will typically not make sense, at least without some further frame or rationale. These kinds of shifts are examples of second-order change. We explain these central concepts on change in more detail in the next several chapters. In accordance with the thesis of this book, we show how second-order change is central to effective treatment.

Understanding the phenomenon of change in this way represents a second-order shift for theorists who are struggling with the integration of seemingly contradictory models of psychotherapy. The state of affairs that so much defines contemporary professional discourse reflects a competition of first-order solutions—who is on top, whose is best, mine is better. A new understanding of the nature of change redirects the debate from an either-or

focus to a more productive both-and direction. We also show that as trainers, students, theorists, researchers, and policymakers understand the nature of change they will be able to integrate the best of what the principal warring camps have to offer. In effect, the blind alleys are only an illusion. Like a labyrinth, the passageway is clear when one follows the golden thread.

The book is divided in two major parts. In the first part, "The Golden Thread of Second-Order Change" (chaps. 1-5), we further elaborate the definitions of first-order and second-order change and apply them to the foundations of effective therapy. Chapter 2 addresses problem formation and the close relationship between stability, change, and vicious cycles. In chapter 3, we turn to second-order change. Examples showing the action of second-order change in a wide range of human dilemmas are presented, with a special focus on psychotherapy. Completing this section, in chapters 4 and 5 we assess what many refer to as the *fundamentals of effective treatment*. In particular, the contribution of the therapeutic alliance and other common factors are reexamined through the perspective of second-order change. These chapters create a framework to demonstrate how the golden thread of second-order change weaves its way through empirically supported therapies.

In the second part of the book, "Following the Thread: Empirically Supported Therapies" (chaps. 6-11), we review a variety of empirically supported approaches for common clinical problems. Specifically, in these chapters we address the two most common mood disorders; the two most frequent relationship complaints; and, finally, two special clinical challenges (e.g., substance abuse and dependency and high-risk emergencies, or *borderline* difficulties). The chapters comprising this major part, six in total, represent the core of the book in terms of applying the second-order change model to therapies that work.

Each clinical chapter follows the same format. To clarify the problem that is being addressed, we formally define the problem. We then analyze the "best practice" or EST recommended for each clinical scenario, including a synopsis of the practical goals and steps and research supporting it. After delineating the approach, we examine the application, but with a difference. We show how second-order change operates as the underlying pathway to improvement in the therapy. Each clinical chapter concludes with a brief summary, titled "Following the Thread," of the principles of second-order change that underlie the approach.

The final chapter of the book, "Following the Golden Thread of Second-Order Change in Effective Psychotherapy," summarizes the implications of viewing and doing therapy from the standpoint of second-order. We present how this unifying perspective can structure and guide the integration of the various psychotherapies, mental health policy and planning, and clinical practice.

In the Greek myth, the warrior Theseus is seeking his way through the labyrinth to end the carnage of the beast, the Minotaur, by killing it once

and for all. Divisiveness in psychotherapy is the Minotaur of our times. It creates an unproductive cycle of in-fighting when we should be proclaiming "What we do works and is worthy of funding." We can make this proclamation only after we realize what unites all therapies. This is the golden thread of second-order change.